

INDIANA MEDICAID HOSPITAL REQUEST FOR SETTLEMENT:

SUSPECTED CHILD ABUSE AND NEGLECT CASES

Indiana Medicaid Provider Number: _____ Date Submitted: _____ Quarter Ended: _____

Medicaid Recipient ID Number (1)	Medicaid Recipient Name (2)	Date of Admission (3)	Medical Discharge Date (4)	CPS Release Date (5)	CPS Worker (6)	Discharge Date (7)	Extended Days (8)	Extended Day Charges (9)	Ancillary Charges (10)

NOTE:

This form does not constitute all required documentation. Supporting documentation should be maintained by the hospital. This includes the patient medical records, copies of correspondence with child protection services, and any other documentation needed to support the child abuse and neglect extended inpatient stay payment.

Within thirty days following the end of the quarter, hospitals should submit this form along with letters of authorization for release from the Department of Child Services for all child abuse and neglect extended stay cases that were discharged during the quarter. Forms should be mailed to Myers and Stauffer LC, ATTENTION Hospital Department, 9265 Counselors Row, Suite 200, Indianapolis, IN 46240-6419.

Additional Column Description

- 1) Indiana Medicaid Recipient Number
- 4) Date the patient is ready to be medically discharged
- 5) Date Department of Child Services (DCS) or Child Protective Services (CPS) authorized release
- 6) Name of the CPS case worker
- 7) Date the patient was discharged from the hospital
- 8) Number of additional days (beyond medical treatment) the patient was in the hospital
- 9) Hospital extended stay charges associated with the additional days in number 8 (excluding ancillary charges)
- 10) Hospital extended stay ancillary charges associated with the additional days in number 8